

November 8, 2012

10 CFR 50.73

Docket No. 50-443 SBK-L-12230

U. S. Nuclear Regulatory Commission Attn: Document Control Desk Washington, DC 20555-0001

Seabrook Station

Licensee Event Report (LER) 2012-003-00

Reactor Trip Due to Circuit Board Failure that Closes Feed Regulating Valve

Enclosed is Licensee Event Report (LER) 2012-003-00. This LER reports an event that occurred at Seabrook Station on September 14, 2012. This event is being reported pursuant to the requirements of 10 CFR 50.73(a)(2)(iv)(A).

Should you require further information regarding this matter, please contact Mr. Michael O'Keefe, Licensing Manager, at (603) 773-7745.

Sincerely,

NextEra Energy Seabrook, LLC

Kevin T. Walsh Site Vice President

cc: NRC Region I Administrator
J. G. Lamb, NRC Project Manager
NRC Senior Resident Inspector

TEZZ NRR

Estimated butter per response to comply with this mandality collections Stroken, Reported less on listensed butter Stroken, Reported less on listensed butter Stroken, Reported less on listensed butter Stroken, Reported less on listensed Stroken, Reported	NRC FOR	RM 366			U.S. N	UCLEA	R RE	GULATOR	RY COMMI	SSION	APPR	OVE	D BY OME	s: NO. 3150-0	04	EXPIRES:	10/31/2013
1. FACILITY NAME	•	Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA/Privacy Section (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet email to infocollects.resourse@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104). Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not															
### A: TITLE Reactor Trip Due to Circuit Board Failure that Closes Feed Regulating Valve	1. FACIL	1. FACILITY NAME 2. DOC								CKE	(ET NUMBER 3. PAGE						
S. EVENT DATE	4. TITLE													A		1013	
MONTH DAY YEAR SEQUENTIAL REV MONTH DAY YEAR FACILITY NAME DOCKET NUME																	
MONTH DAY YEAR YEAR NUMBER NO. MONTH DAY YEAR NUMBER NO. NUMBER NO. NUMBER	5. E	VENT D	ATE	6.	T			7. R	EPORT D	ATE	FAC	ILITY		OTHER FAC	ILITIES INVO		NUMBER
9. OPERATING MODE 11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR§: (Check all that apply) 20.2201(b)	MONTH	DAY	YEAR	YEAR				MONTH	DAY	YEAR	₹						
20.2201(b)	09	14							DOCKET	NUMBER							
1	9. OPERATING MODE 11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR§: (Check all that apply)																
Michael O'Keefe, Licensing Manager TELEPHONE NUMBER (Include Area Code 603-773-7745 13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT CAUSE SYSTEM COMPONENT MANU-FACTURER REPORTABLE TO EPIX CAUSE SYSTEM COMPONENT MANU-FACTURER REPORTABLE TO EPIX TO EPIX CAUSE SYSTEM COMPONENT MANU-FACTURER REPORTA TO EPIX TO EPI	10. POW	ER LEVI	E L .	☐ 20.2201(d) ☐ 20.2203(a)(1) ☐ 20.2203(a)(2)(ii) ☐ 20.2203(a)(2)(iii) ☐ 20.2203(a)(2)(iii) ☐ 20.2203(a)(2)(iv) ☐ 20.2203(a)(2)(v) ☐ 20.2203(a)(2)(vi)				☐ 20.2203(a)(3)(ii) ☐ 20.2203(a)(4) ☐ 50.36(c)(1)(i)(A) ☐ 50.36(c)(2) ☐ 50.46(a)(3)(ii) ☐ 50.73(a)(2)(i)(B)			☐ 50.73(a)(2)(ii)(A) ☐ 50.73(a)(2)(ii)(B) ☐ 50.73(a)(2)(iii) ☐ 50.73(a)(2)(iv)(A) ☐ 50.73(a)(2)(v)(A) ☐ 50.73(a)(2)(v)(B) ☐ 50.73(a)(2)(v)(C) ☐ 50.73(a)(2)(v)(D)			(2)(ii)(A) (2)(ii)(B) (2)(iii) (2)(iv)(A) (2)(v)(A) (2)(v)(B) (2)(v)(C)	☐ 50.73(a)(2)(viii)(A) ☐ 50.73(a)(2)(viii)(B) ☐ 50.73(a)(2)(ix)(A) ☐ 50.73(a)(2)(ix)(A) ☐ 50.73(a)(2)(x) ☐ 73.71(a)(4) ☐ 73.71(a)(5)		
Michael O'Keefe, Licensing Manager 13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT CAUSE SYSTEM COMPONENT MANU-FACTURER REPORTABLE TO EPIX ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) On September 14, 2012 at 8:25 pm while operating at approximately 85% power, Seabrook Station experienced an automatic reactor trip on low steam generator (SG) water level. The failure of a printed circuit board in the 7300 process control system caused the feedwater regulating valve for SG-C to close. As a result, the water level in SG-C decreased to the low level trip setpoint and initiated an automatic reactor trip. The emergency feedwater system actuated on low SG level, and plant equipment functioned as expected. No adverse consequences resulted from this event. The root cause of the event was the failure of an internal component on a printed circuit board (manual nuclear tracking driver board) in the 7300 control system. The corrective actions included replacing the failed circuit	NAME						12	. LICENSE	EE CONT	ACT FC	R THI	SLE	R	[TEL	EPHONE NUMBE	R (Include Are	n Code)
CAUSE SYSTEM COMPONENT FACTURER REPORTABLE TO EPIX JB CBD W120 Y 14. SUPPLEMENTAL REPORT EXPECTED YES (If yes, complete 15. EXPECTED SUBMISSION DATE) On September 14, 2012 at 8:25 pm while operating at approximately 85% power, Seabrook Station experienced an automatic reactor trip on low steam generator (SG) water level. The failure of a printed circuit board in the 7300 process control system caused the feedwater regulating valve for SG-C to close. As a result, the water level in SG-C decreased to the low level trip setpoint and initiated an automatic reactor trip. The emergency feedwater system actuated on low SG level, and plant equipment functioned as expected. No adverse consequences resulted from this event. The root cause of the event was the failure of an internal component on a printed circuit board (manual nuclear tracking driver board) in the 7300 control system. The corrective actions included replacing the failed circuit				М	ichael (O'Kee	efe, l	_icensing	g Manag	jer						*	
TO EPIX X JB CBD W120 Y 14. SUPPLEMENTAL REPORT EXPECTED YES (If yes, complete 15. EXPECTED SUBMISSION DATE) On September 14, 2012 at 8:25 pm while operating at approximately 85% power, Seabrook Station experienced an automatic reactor trip on low steam generator (SG) water level. The failure of a printed circuit board in the 7300 process control system caused the feedwater regulating valve for SG-C to close. As a result, the water level in SG-C decreased to the low level trip setpoint and initiated an automatic reactor trip. The emergency feedwater system actuated on low SG level, and plant equipment functioned as expected. No adverse consequences resulted from this event. The root cause of the event was the failure of an internal component on a printed circuit board (manual nuclear tracking driver board) in the 7300 control system. The corrective actions included replacing the failed circuit			1	3. COM	PLETE O	NE LII	NE F	OR EACH	COMPON	IENT F	AILUR	E DE	SCRIBE	D IN THIS R	PORT		
14. SUPPLEMENTAL REPORT EXPECTED YES (If yes, complete 15. EXPECTED SUBMISSION DATE) On September 14, 2012 at 8:25 pm while operating at approximately 85% power, Seabrook Station experienced an automatic reactor trip on low steam generator (SG) water level. The failure of a printed circuit board in the 7300 process control system caused the feedwater regulating valve for SG-C to close. As a result, the water level in SG-C decreased to the low level trip setpoint and initiated an automatic reactor trip. The emergency feedwater system actuated on low SG level, and plant equipment functioned as expected. No adverse consequences resulted from this event. The root cause of the event was the failure of an internal component on a printed circuit board (manual nuclear tracking driver board) in the 7300 control system. The corrective actions included replacing the failed circuit	CAUSE SYSTEM			СОМРО	NENT					CAUSE			SYSTEM	COMPONEN			
PYES (If yes, complete 15. EXPECTED SUBMISSION DATE) ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) On September 14, 2012 at 8:25 pm while operating at approximately 85% power, Seabrook Station experienced an automatic reactor trip on low steam generator (SG) water level. The failure of a printed circuit board in the 7300 process control system caused the feedwater regulating valve for SG-C to close. As a result, the water level in SG-C decreased to the low level trip setpoint and initiated an automatic reactor trip. The emergency feedwater system actuated on low SG level, and plant equipment functioned as expected. No adverse consequences resulted from this event. The root cause of the event was the failure of an internal component on a printed circuit board (manual nuclear tracking driver board) in the 7300 control system. The corrective actions included replacing the failed circuit	Х		JB	CB	D	W12	0	Y	7								
On September 14, 2012 at 8:25 pm while operating at approximately 85% power, Seabrook Station experienced an automatic reactor trip on low steam generator (SG) water level. The failure of a printed circuit board in the 7300 process control system caused the feedwater regulating valve for SG-C to close. As a result, the water level in SG-C decreased to the low level trip setpoint and initiated an automatic reactor trip. The emergency feedwater system actuated on low SG level, and plant equipment functioned as expected. No adverse consequences resulted from this event. The root cause of the event was the failure of an internal component on a printed circuit board (manual nuclear tracking driver board) in the 7300 control system. The corrective actions included replacing the failed circuit									-			SUBMISSION		MONTH	DAY	YEAR	
On September 14, 2012 at 8:25 pm while operating at approximately 85% power, Seabrook Station experienced an automatic reactor trip on low steam generator (SG) water level. The failure of a printed circuit board in the 7300 process control system caused the feedwater regulating valve for SG-C to close. As a result, the water level in SG-C decreased to the low level trip setpoint and initiated an automatic reactor trip. The emergency feedwater system actuated on low SG level, and plant equipment functioned as expected. No adverse consequences resulted from this event. The root cause of the event was the failure of an internal component on a printed circuit board (manual nuclear tracking driver board) in the 7300 control system. The corrective actions included replacing the failed circuit												ATE	<u> </u>	*			
	On ex bo the em ad Th tra	Septe perience ard in the water nergence verse control cking d	mber 14 sed an a he 7300 level in cy feedw consequ cause of	I, 2012 utomal proce SG-C vater sy ences f the ev ard) in	at 8:25 cic react ss control decreas ystem a resulted yent was the 730	o pm valor triperol sy sed to actuate differom sthe 200 cores	while on stem the other the other the other the other this failuntrol	e operati low stea n caused low leve n low SO s event. re of an system.	ng at ap am gene I the fee el trip se G level, a internal The co	proxirerator (dwate tpoint and plant comporrective)	nately SG) v r regu and ii ant ec	wate ulati nitia quip : on	er level. ng valve sted an a ment fu a printe	The failure for SG-Cautomatic nctioned a	e of a prin to close. reactor trip is expected pard (man	As a res . The d. No ual nucle	eult,

LICENSEE EVENT REPORT (LER) CONTINUATION SHEET

1. FACILITY NAME	2. DOCKET		6. LER NUMBE	3. PAGE	
Combined Chating	05000443	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Seabrook Station		2012	- 003 -	00	Page 2 of 3

NARRATIVE

Description of Event

On September 14, 2012 at 8:25 pm while operating at approximately 85% power, Seabrook Station experienced an automatic reactor trip on low steam generator (SG)[AB, SG] water level. The failure of a printed circuit board [JB, CBD] in the 7300 process control system caused the feedwater regulating valve [SJ, FCV] for SG-C to close. As a result, the water level in SG-C decreased to the low level trip setpoint and initiated an automatic reactor trip. The emergency feedwater system [BA] actuated on low SG level, and plant equipment functioned as expected.

Cause of Event

The root cause of the event was the failure of an internal component on a printed circuit board (manual nuclear tracking driver board) in the 7300 control system.

Analysis of the Event

The 7300 control system instrument loops for the feedwater regulating valves include three circuit boards: a nuclear controller board (NCB), an automatic (auto) nuclear tracking driver (NTD) board, and a manual NTD board. During operation in auto, the NCB receives inputs from the SG level controller and the difference between feed and steam flow. The NCB then provides an input to the auto NTD board, which provides an output to control the position of the feedwater regulating valve. If the manual NTD board fails when the instrument loop is in auto, the loop will revert to a manual mode that is controlled by the auto NTD board.

During operation in the manual mode, the output of the manual NTD board controls the position of the feedwater regulating valve. In this mode, the NCB and auto NTD board track the output of the manual NTD to permit a bump less transfer to the auto mode.

A failure of the manual NTD board initiated this event. A failure of a circuit board is detected when the fuse [JB, FU] on the circuit board opens. The internal failure on the manual NTD board transferred control to the manual mode and also caused the manual NTD board output to decrease (which provided a close signal to the feedwater regulating valve) prior to the fuse opening. At the same time, the auto NTD board tracked the decreasing output from the manual NTD board. Subsequently, when the fuse on the manual NTD opened, the instrument loop reverted to the manual mode with control by the auto NTD board. However, since the output of the auto NTD had decreased, the feedwater regulating valve was nearly closed, and SG water level decreased to the low level reactor trip setpoint.

This event resulted in a valid actuation of the reactor protection system and met the reporting criteria of 10 CFR . 50.72(b)(3)(iv)(A). A four hour report was made to the NRC at approximately 2205 on September 14, 2012 (event number 48310). The operators responded to the plant trip in accordance with approved procedures, and safety systems functioned as expected. No adverse consequences resulted from this event, and this incident had no adverse impact on the health and safety of the public or the plant and its personnel. This event did not involve a safety system functional failure. No inoperable structures, systems, or components contributed to this event.

Corrective Actions

The corrective actions included replacing the failed circuit card and three additional cards in the same instrument loop.

NRC FORM 366A

U.S. NUCLEAR REGULATORY COMMISSION

(10-2010)

LICENSEE EVENT REPORT (LER) CONTINUATION SHEET

1. FACILITY NAME	2. DOCKET		6. LER NUMBE	3. PAGE	
Cook work Otation	05000443	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Seabrook Station		2012	- 003 -	00	Page 3 of 3

NARRATIVE

Similar Events

Seabrook has experienced no similar events within the last five years involving a plant trip due to failure of a 7300 control system card.

Additional Information

The Energy Industry Identification System (EIIS) codes are included in this LER in the following format: [EIIS system identifier, EIIS component identifier].